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E 000	Initial Comments An unannounced recertification survey was conducted on 6/24/19 through 6/27/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MR1K11.	E 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		7/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/12/2019

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F 656	Continued From page 1 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to implement a care plan for hearing to ensure the resident's hearing aids were in place and in good working order for 1 of 1 residents reviewed for hearing/ vision (Resident #20). Additionally, the facility failed to develop a comprehensive care plan for resting hand splinting devices per Occupational Therapy reccommendation for 2 of 3 residents reviewed for range of motion (Resident #30 and Resident #15). The findings included: 1. Resident #20 was readmitted to the facility on 03/23/18. Resident #20's diagnoses included diabetes mellitus, non- Alzheimer's dementia, hypertension and depression. Review of the comprehensive Minimum Data Set (MDS) dated 04/08/19 revealed Resident #20 was cognitively intact for daily decision making and required extensive assistance of one staff member for most activities of daily living (ADL). The MDS further revealed that Resident #20 had moderate difficulty with hearing and did not wear	F 656	Facility failed to follow resident # 20's care plan for hearing aid. Resident #20's hearing aid was placed in resident ear per the care plan. Facility failed to ensure resident #30 and resident #15 had a Care Plan for applying sprigs as per Occupational Therapy recommendation. Facility has written Care Plan for resident #30 and resident #15 as per OT recommendations. Director of Nursing (DON) has completed an audit on 6/24/2019 of all residents for splint and hearing aid use; all Care Plans have been updated as needed. The Interdisciplinary Team will audit/review on admission any new residents with hearing aids or splints and other assistive devices to ensure Care Plans are initiated upon admission. DON and/or Designee has in-serviced all	

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F 656	Continued From page 2 a hearing aid. Review of Resident #20's care plan dated 12/09/2018 revealed a focus area for hearing, the goal was for the resident to demonstrate the ability to hear by answering questions appropriately. An intervention documented included ensuring Resident #20's hearing aids were in place and in good working order. An observation of Resident #20 was made on 06/24/19 at 10:15 AM. Resident #20 was observed in her room sitting in her wheelchair with no hearing aids in, Resident #20 was observed having extreme difficulty hearing the surveyor and staff members. An interview was conducted with Resident #20 on 06/24/19 at 10:15 AM. During the interview she stated she had hearing aids in her room however was not able to put them in herself due to decreased range of motion in her left arm. Resident #20 stated she wished she could wear them and had asked staff for assistance with placement of her hearing aids however no one had assisted her with them. On 06/25/19 at 2:00 PM an interview was conducted with Nurse #1. The interview revealed she was Resident #20's nurse and was very familiar with the resident. She stated she had never known of Resident #20 wearing hearing aids and did not believe the resident had hearing aids in her room. On 06/25/19 at 2:57 PM an interview was conducted with Nursing Assistant (NA) #1. She stated Resident #20 had difficulty hearing however did not know if the resident had hearing	F 656	staff on 6/24/19 on the use of and applying hearing aids and placing splints. DON has placed order on all resident MAR for in and out times. DON/Designee will monitor all hearing aids 5 times per week for 4 weeks; then 3 times per week for 4 weeks; and then weekly for 4 weeks. DON/Designee will review all splint orders 5 times per week for 4 weeks; then 3 times per week for 4 weeks; then weekly for 4 weeks. DON will report all findings to the QAPI monthly for 3 months. Interdisciplinary team will review findings and make any necessary changes to monitoring as needed.	

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aids. The interview revealed for residents with hearing aids the information was placed under an alert in the Matrix system to alert NAs to ensure the hearing aids were being placed. She stated Resident #20 did not have hearing aids listed under her alerts in the Matrix system.

On 06/25/19 at 3:36 PM an interview was conducted with NA #2. During the interview he stated Resident #20 was hard of hearing however did not wear hearing aids. He stated he had never seen her wearing hearing aids nor seen them in her room.

On 06/25/19 at 4:06 PM an interview was conducted with the Director of Nursing (DON). The interview revealed she did not know if Resident #20 had hearing aids. She stated she went into Resident #20's room to ask the resident and discovered she did have hearing aids in her room in a bottom drawer. She discovered the hearing aids were missing the batteries and were not in working order. The interview revealed they were not following the residents care plan by ensuring the hearing aids were in place and working, she stated she would place a physician's order for the nurse to be aware Resident #20 had hearing aids and to apply them daily. She stated she would send a staff member to purchase batteries for the residents hearing aids.

On 06/26/19 at 8:19 AM an interview was conducted with Resident #20. She was observed sitting in the dining room awaiting her breakfast meal during the interview with a smile on her face. Resident #20 stated, "I can hear now, I don't have to turn my head to the side to hear your voice". Resident #20 stated was was excited to be wearing her hearing aids.

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2. Resident #30 admitted to the facility on 12/24/2017. Diagnoses included hemiplegia right dominant side, muscle weakness, cerebral infarction.

Review of the Quarterly Minimum Data Set (MDS) dated 4/12/2019 revealed Resident #30 had severe cognitive impairment. She required extensive assistance from staff and had impairments to bilateral upper extremities related to functional limitation in range of motion. Review of Section O (Special Treatments, Procedures and Programs) revealed Resident #30 received occupational and physical therapies during this assessment period.

Review of the Occupational Therapy Discharge Summary dated 5/24/2019 revealed Resident #30 had a recommendation for a right resting hand splinting device to be worn four (4) hours per day.

Review of Resident #30's revised plan of care dated 4/11/2019 revealed no care plan in place for a right resting hand splinting device.

An observation was completed on 6/24/2019 at 9:25 AM of Resident #30's room. A blue splinting device was observed on the night stand.

An observation was completed on 6/26/2019 at 12:23 PM of Resident #30. Resident #30 was observed up in her wheelchair in dining room. A blue splinting device was observed to be applied to the right hand/ wrist area.

An interview was completed on 6/25/2019 at 10:39 AM with the MDS Nurse. The MDS Nurse stated she was aware Resident #30 had a right

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resting hand splinting device. The MDS Nurse stated the right resting hand splinting device should have been developed into a plan of care. The MDS Nurse stated the MDS department would be responsible for the development of that care plan and she would take care of it immediately.

An interview was completed on 6/25/2019 at 2:31 PM with the Director of Nursing (DON). The DON stated her expectation would be for the MDS department, in conjunction with the Interdisciplinary Team, to develop the plan of care for splinting devices.

An interview was completed on 6/26/2019 at 10:48 AM with the Rehab Manager. The Rehab Manager stated the splinting device was still appropriate for Resident #30 and should continue to be applied by staff for contracture management.

3. Resident #15 was admitted to the facility on 7/23/2018. His diagnoses included hemiplegia affecting left non-dominant side and muscle weakness.

Review of the Quarterly Minimum Data Set (MDS) dated 4/4/2019 revealed Resident #15 had moderate cognitive impairment. He required extensive assistance from staff and had impairments to bilateral upper extremities related to functional limitation in range of motion. Resident #15 was not receiving therapy services during this assessment period.

Review of the Occupational Therapy Discharge summary dated 1/24/2019 revealed Resident #15 had a recommendation for a left resting hand

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splinting device to be worn up to thirty (30) minutes at a time per day for contracture management.

Review of Resident #15's revised plan of care dated 4/4/2019 revealed no care plan in place for a left resting hand splinting device.

An observation was completed on 6/24/2019 at 10:44 AM of Resident #15 in his room. Resident #15 was up in his wheelchair resting with his eyes closed. Further observation of Resident #15's room revealed a blue splitting device on his dresser.

An observation was completed on 6/25/2019 at 10:06 AM of Resident #15 in his room. Resident #15 was observed in his bed sleeping. Resident #15 had a left resting hand splinting device applied.

An interview was completed on 6/25/2019 at 10:39 AM with the MDS Nurse. The MDS Nurse stated she was aware Resident #15 had a left resting hand splinting device. The MDS Nurse stated the left resting hand splinting device should have been developed into a plan of care. The MDS Nurse stated the MDS department would be responsible for the development of that care plan and she would take care of it immediately.

An interview was completed on 6/25/2019 at 2:31 PM with the Director of Nursing (DON). The DON stated her expectation would be for the MDS department, in conjunction with the Interdisciplinary Team, to develop the plan of care for splinting devices.

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F 656	Continued From page 7 An interview was completed on 6/26/2019 at 10:48 AM with the Rehab Manager. The Rehab Manager stated the splinting device was still appropriate for Resident #15 and should continue to be applied by staff for contracture management.	F 656		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to discard an	F 761	Facility failed to remove an expired bottle of Iron Liquid and Acetaminophen and	7/25/19

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F 761	Continued From page 8 opened expired bottle of Acetaminophen Liquid and an opened expired bottle of Iron Liquid which were available for use in 1 of 3 medication carts. The facility also failed to label an opened tube of Muscle Rub cream available for use in 1 of 3 medication carts. Findings included: Review of the facility's policy named "Storage of Medications" revised on April 2007 revealed the following statements: #3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. #4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. An observation made of the Medication Cart for rooms 110-119 with the Certified Medication Technician (CMT) #1 on 6/27/19 at 9:45 AM revealed the following: 1. An opened bottle of Acetaminophen Liquid and an opened bottle of Iron Liquid had an expiration date of 5/19. Both bottles had a sticker that read "use now, short dated." 2. An opened tube of Muscle Rub cream on the third left drawer of the medication cart was stored in a plastic bag. The tube did not have a label as to which resident it was for. Interview conducted with CMT #1 on 6/27/19 at 9:45 AM revealed she checked the medication carts assigned to her once a week. She had just checked the Medication Cart for rooms 110-119 but failed to discard the expired bottles of	F 761	muscle rub from cart #1. Expired bottle of Iron Liquid, Acetaminophen and muscle rub were removed from cart #1 on 6/27/2019 and discarded. Director of Nursing (DON) and or Designee have checked all medication rooms and medication carts for unlabeled and expired medications on 6/27/2019. DON educated CMT#1 on "use by" versus "expires on" dates on medications on 6/27/2019. DON/Designee has completed in-service for all nurses and Medication Aids on labeling and removing expired medications to include muscle rubs on 7/1/2019. DON/Designee will check all medication carts and medication rooms 5 times per week for 4 weeks; then check all medication room and medication carts weekly for 3 months. DON will report all findings to the QAPI committee monthly. The Administrator and IDT team will review findings and make any necessary changes as needed to ensure continued compliance.	

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F 761	Continued From page 9 Acetaminophen and Iron Liquid due to thinking the 5/19 marking on the bottles were not expiration dates as they were not marked as "use by" or "expires on." She stated she thought the bottles were expiring one year from the 5/19 label on the bottles. She said she had not given any Acetaminophen Liquid or Iron Liquid that day. CMT #1 further stated the Muscle Rub cream on the third left drawer of the medication cart was intended to be used for one resident only, but she forgot to put the resident's name on the tube. She also said that she had not used it for a resident on that day. An interview was conducted with the Director of Nursing (DON) on 6/27/19 at 10:09 AM, with the Administrator present. The DON stated the Acetaminophen Liquid and Iron Liquid were expired and should have been discarded after 5/31/19. She further stated the tube of Muscle Rub cream which was intended for single resident use should have been labeled with the resident's name. She said these should have been taken care of when the medication cart was inspected this week.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		7/25/19

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F 812	Continued From page 10 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to keep the interior compartment of the kitchen's ice machine clean, failed to maintain clean filters in the ice machine, and failed to remove ice from inside the ice machine while the machine's interior was being cleaned for 1 of 2 facility ice machines. The findings included: An initial tour of the kitchen on 06/24/19 at 9:11 AM revealed an accumulation of a pink substance that was able to be easily removed with a towel was on the hot shield of the kitchen's ice machine. The ice machine's hot shield was located inside the machine over where ice was stored. The 2 filters on the ice machine were observed to be covered with dust. The ice machine was observed to have ice in its storage compartment that was ready for use. An interview with the Assistant Dietary Manager on 06/24/19 at 9:12 AM revealed kitchen staff were responsible for cleaning the interior and exterior of the kitchen's ice machine and cleaning the machine's filters. The Assistant Dietary Manager stated the outside of the ice machine was wiped down daily and there was no set	F 812	Facility failed to ensure ice machine in kitchen was clean. Ice machine has been emptied and all parts cleaned (to include the hot shield, all filters and all surfaces, inside and out) by the Assistant Dietary Manager on 6/27/2019. Dietary Manager checked ice machine on 300 hall to ensure it was cleaned. Dietary Manager in-serviced all dietary staff on ice machine cleaning and the cleaning schedule on 6/27/2019. Dietary Manager and or Designee will inspect the ice machine daily for 4 weeks; then weekly thereafter for one month; then monthly for 3 months. Dietary Manager/Designee will clean ice machine monthly and have it serviced and cleaned yearly by refrigeration company. Dietary Manager will report finding to the QAPI committee monthly for 6 months. The Administrator will review findings in QAPI for any needed changes to current	

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F 812	Continued From page 11 schedule for cleaning the rest of the ice machine. The Assistant Dietary Manager stated there should not be a pink substance on the hot shield of the ice machine and the filters should not be covered with dust. The Assistant Dietary Manager stated that all residents who received meal trays could receive ice prepared from the kitchen's ice machine. A follow up observation of the ice machine in the kitchen on 06/25/19 at 11:12 AM revealed the pink substance was gone from the hot shield in the ice machine and the 2 filters were free of dust. A subsequent interview with the Assistant Dietary Manager on 06/25/19 at 11:13 AM revealed she and Dietary Aide #1 removed the hot shield from the ice machine on the afternoon of 06/24/19 and cleaned the hot shield and the 2 filters of the ice machine. The Assistant Dietary Manager stated she and Dietary Aide #1 did not remove the ice from the ice machine but placed trash bags over the ice while the hot shield was cleaned. The Assistant Dietary Manager stated the same ice that was in the ice machine when the pink substance was identified on the hot shield was used for lunch and dinner meals on 06/24/19 and the breakfast meal on 06/26/19. The Assistant Dietary Manager stated the ice machine was last cleaned 05/30/19 prior to being cleaned 06/24/19. An interview with Dietary Aide #1 on 06/25/19 at 11:15 AM revealed she and the Assistant Dietary Manager cleaned the hot shield of the ice machine in the kitchen the afternoon of 06/24/19 and did not remove or discard the ice at the time the ice machine was cleaned.	F 812	monitoring.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE HEALTH AND REHABILITATION	111 HARRILSON STREET CHERRYVILLE, NC 28021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 12 An interview with the Administrator on 06/27/19 at 9:47 AM revealed she expected the kitchen's ice machine to be clean and not visibly soiled and to be cleaned at least once a month. The Administrator stated the ice should not have been served after the pink substance on the hot shield and the dust on the filters were identified.	F 812		